A Call to Action: The Precarious State of the Board and Care System Serving Residents Living with Mental Illness in Los Angeles County

Prepared by the

Los Angeles County Mental Health Commission

Ad-hoc Committee on LA County's Board and Care System

Members

Caroline Kelly, Immediate Past Chair LA County Mental Health Commission

Barbara B. Wilson, LCSW

Kerry Morrison, Stanton Fellow 2016-17

Brittney Weissman, NAMI LA County Chapter

January 22, 2018

Table of Contents

STATEMENT OF THE PROBLEM

Board and care homes (technically referred to as Adult Residential Facilities) represent a precious and affordable housing resource for individuals suffering from mental illness. These facilities range in size from 6 beds (in a single-family home) to 100+ beds. They are privately operated by homeowners or for-profit corporations. Adult Residential Facilities are 24-hour, non-medical community facilities regulated by the state Community Care Licensing Division. Residents present a continuum of need, ranging from those able to hold down a job on one end of the spectrum, to those who have been released from locked psychiatric facilities on the other end of the spectrum. Yet despite this continuum of need, the daily "rent" paid to a board a care operator in LA County is $35.[1] Operators of board and care homes are increasingly questioning the sustainability of this business model in the face of increasing costs on all fronts (increases in minimum wage, insurance costs, utility increases and accumulated deferred maintenance).

In a preliminary canvasing of board and care operators, the Department of Mental Health believes that in Service Area 2 alone, there may be a closure and loss of as many as 400 beds over the next 18 months. Extrapolated across the county, this results in a significant loss that outpaces the additional housing currently being planned.

Further, given the service needs of this population, the meagre reimbursement does not provide for any type of therapeutic enrichment, community-building or case management.

The board and care system for mentally ill residents is a non-sustainable business model and does not contribute to a meaningful treatment environment which will contribute to a quality of life and/or prevent residents falling back into homelessness. Absent a corrective action, this housing resource will continue to erode.[2]

I. SOLUTION SNAPSHOT

There needs to be an infusion of resources – this year -- into the board and care system to ensure its survival. Supplemental funding, above and beyond what the residents can pay through their government benefits,[3] would provide incentives to operators to continue housing people living with mental illness. The infusion needs to be substantial enough to forestall the loss of precious beds through: (1) the closure of these facilities, (2) the sale of these properties for residential or commercial

---

[1] For this reimbursement, the board and care must provide three meals a day plus two snacks, a room and bedding, laundry, a well-maintained and safe facility, money management and access to health or psychiatric care professionals.

[2] The long-awaited study from the California Mental Health Planning Council (CMHPC), October 2017, started its report by saying: "This issue paper is the beginning of an effort to highlight a significant public health issue: **the lack of adult residential facilities as housing options for individuals with serious mental illness in California."**

[3] According to the CHMPC October 2017 report, "monthly rates charged by ARF's are driven by the amount of the Social Security Income/State Supplemental Payment (SSI/SSP) amount paid to Californian's with disabilities and who are unable to work. The SSI/SSP payment, as sole source f payment for the individual residing in an ARF, is not sufficient to provide adequate income for the operation of a licensed ARF especially when some about of the SSI/SSP payment is set aside for personal needs of the individuals. Therefore subsidies, often called "patches" are needed." Page 6.

development, or (3) the conversion of these facilities to those serving other populations which offer a higher daily rental rate (e.g., $85 – $150 for homes for individuals with intellectual disabilities).[4] (See Appendix D for additional information.)

Four options are worth exploring to provide these supplemental resources:

a. Reestablishment of the supplemental funding that was made available to LA County board and care facilities up until approximately nine or ten years ago when the head of county DMH Dr. Marvin Southard eliminated this program—and not just to a few places that will take more special cases;
b. Allocation of a portion of the "No Place Like Home" $2B funding that will become available, representing a re-direction of funds already available through the Prop 63 Millionaire's Tax. These funds could be deployed to counteract the deferred maintenance associated with many of these facilities and serve as a source of capital investment.
c. Tapping into a portion of the funds that have been made available through Measure HHH, the LA City general obligation bond to support permanent supportive housing for chronically homeless individuals, which city voters approved in November 2016;
d. Tapping into county funds raised Measure H, passed by county voters on the March 2017 ballot.

II. BACKGROUND

a. Residential Options for Persons Living with Mental Illness

People living with a serious mental illness account for less than six percent of the population[5]. With the shift away from state institutions that commenced in the last 1970's, and the lack of community-based treatment programs and facilities that were promised as an alternative, hundreds of thousands of individuals in the US suffering from mental illness have either been "reinstitutionalized" in prisons and jails, or are homeless. The remainder who have housing are primarily in one of three places:

- Living at home with family
- Living in permanent supportive housing as part of the "Housing First" movement to move people experiencing homelessness from the street into a living unit
- Living in privately operated "board and care" facilities.

In Los Angeles County, where the most recent point-in-time homeless count identified 57,794 homeless people, the number of people living with mental illness far exceeds the housing options available. The 2017 demographic survey conducted by the Los Angeles Homeless Authority (LAHSA) identified that 30 percent of the homeless population in Los Angeles County suffers from a serious mental illness. That would amount to approximately 15,728 people.

[4] "Disparities in Reimbursement Rates." Chart prepared by Barbara B. Wilson, LCSW, is attached as an Exhibit.
[5] Source: *Insane Consequences* by DJ Jaffee, referencing research conducted at the time SAMHSA's Center for Mental Health Services was created. The definition defines serious mental illness in adults as, "those mental illnesses that met the criteria of [latest edition of] DSM and ... resulted in functional impairment which substantially interferes with or limits one or more major life activities."

Further, the Los Angeles County jail is generally characterized as one of the largest mental institutions in the country, with over 4,700 inmates incarcerated suffering from mental illness.

With the expressed city/county goal to end chronic homelessness in LA County, which is a national objective as well, attention must be paid to all housing options available, or in the pipeline, to house people living with mental illness.

This report shines a light on the state of the board and care system in L.A. County, which represents a precious housing resource for people living with mental illness. The board and care system provides a residential setting for adults and provides supervision, support, protection and security in a group setting. The provider must be licensed by the Department of Health and Human Resources, Office of Health Facilities Licensure and Certification.

Last year, Los Angeles County managed to house over 14,000 people, a record amount and yet still ended up with an increase of 23% in its homeless population. Analysis points to many reasons with significant ones being the erosion of current affordable housing stock and issues of NIMBYism when it comes to the development of more affordable housing.

The board and care system is precariously resourced and prospects for the continued vitality of this system in the wake of shockingly low daily rental rates per resident ($35) is jeopardized. The failure of this system could exacerbate the homeless situation in LA County with residents exiting board and cares back into homelessness and/or board and care facilities no longer being available to accept new residents.

b. Types of Adult Residential Facilities (ARF's)

Adult Residential Facilities[6] are regulated by the Community Care Licensing Division (CCLD) of the State of California. The provisions are articulated in the Community Care Facilities Act of the Health and Safety Code. Typically, the services provided by an ARF include lodging, food service, care and supervision[7], assistance with taking medications in accordance with a physician's order, assistance with transportation to medical and dental appointments, planned activities, housekeeping, laundry service and maintenance or supervision of cash reserves.

The Community Care Licensing Division oversees several types of residential and day facilities (e.g., Residential Care Facilities for the Chronically Ill, or Residential Care Facilities for the Elderly, to name just two) but for the purposes of this report, we are focusing on what is typically referred to as a board and care, or ARF, in the vernacular of the state.

[6] An Adult Residential Facility means any facility of any capacity that provides 24-hour a day nonmedical care and supervision to the following: (A) persons 18 years of age through 59 years of age; and (B) persons 60 of age and older only in accordance with Section 85068.4 (Acceptance & Retention Limitations) [Source: Community Care Licensing Division (CCLD) report presented by Claire Matsushita, Asst. Program Administrator, to LA County Mental Health Commission on April 27, 2017.]

[7] "Care and Supervision" means those activities which, if provided, shall require the facility to be licensed. It involves assistance as needed with activities of daily living and the assumption of varying degrees of responsibility for the safety and well-being of the residents. [Source: CCLD report]

ARF's may serve people suffering from a mental illness, people with developmental disabilities or elderly residents. They generally do not provide skilled nursing services, with some exceptions.[8]Some facilities are exempted from the CCL licensing process, and there is anecdotal evidence that some formerly licensed board and care homes are shifting to the unlicensed domain. For example, a home or facility that supplies room and board only, with no elements of personal care, is not licensed. These facilities operated "under the radar" and are not subject to any type of regulatory oversight. Recovery houses for persons recovering from substance abuse are also not licensed. (See Appendix A.)

c. The Inventory

The challenge of this research has been to identify the trends with respect to available beds for persons suffering from mental illness. Anecdotal evidence suggests that board and care operators are closing down their facilities and selling their property *at an alarming rate.* While the department has kept track of board and care facilities that it has contracts with, this pool is small compared to all inventory. In meetings with DMH department staff in Q4 2017, we asked for:

- Trends over a two to five-year period documenting number of facilities closing and number of beds impacted.
- Breakdown of current inventory of housing for mentally ill as compared to elderly or intellectual disabilities.
- Information about all board and care facilities in the county, not just those with whom the county has an agreement.

As they say, you can't manage what you don't measure, so the lack of data is an impediment to any effort to stem the loss of more beds for this population.

DMH is in the process now of ramping up its efforts to track this information. This positive development is in part due to the internal resetting of priorities and emphasis under the new Director. We also believe that this invigorated effort is in part in response to this Ad Hoc Committee's work. The timing and request of the recent motion by the Board of Supervisors to track housing for a real time data base has also been a significant factor. In response to the Board Motion, DMH has assigned staff to move forward with soliciting and developing a resource manager and locator for 24hr services. They are currently doing a process improvement analysis to help determine what the scope and functionality of the application needs to be. They still will need to use that scope to find the best application for this need.

This process is not yet complete though and *we ask the Board to continue to expect, encourage and enable the department to gather this information.*

[8] According to the CMHPC report, "Residential care facilities are not allowed to provide skilled nursing services, such as give injections nor maintain catheters nor perform colostomy care (unless there is a credentialed RN or LVN individual working in the home), but they can provide assistance with all daily living activities, such as bathing, dressing, toileting, urinary or bowel incontinency care." P. 3.

The Mental Health Commission organized presentations on this topic at the April 27, 2017 general commission meeting. At that time, which is still the most current data we have, **CCLD reported that in Los Angeles County there are 1,283 Adult Residential Facilities with a bed capacity of 11,979.**

What we have not been able to determine is the breakdown of population served by these facilities. At a minimum, these would be important data points to track:

- Current number of facilities serving people suffering from mental illness. Number of beds and ***how this has changed over time.***
- Current number of facilities serving people living with intellectual disabilities and change over time.
- Current number of facilities serving adult elderly or other needs and change over time.

Absent this data, it is impossible to provide a snapshot of trends. Anecdotal evidence, however, suggests that there is an erosion of bed availability for persons with mental illness due to either closure of facilities for economic reasons, shift to an unlicensed facility[9] or conversion to serve a population where the reimbursement rate is higher. This anecdotal trend also begs the question: are there any new facilities coming on line to add beds to a system that appears to be stressed? If not, what is the reason for lack of entry into this market?

Further, it would be important to know how many *unlicensed* board and care facilities in the county serve persons with mental illness. An unlicensed facility will sometimes recruit residents from licensed facilities by promising them the ability to retain more of their monthly disability check. These facilities will vary wildly in quality and in the degree of services provided. Over the years DMH has had many conversations with County Counsel and the Auditor-Controller about unlicensed facilities. They have raised some concerns including monitoring and quality of care issues. And yet, we know that many of our residents are living in these facilities. We do not know how many of these facilities would be willing to become licensed if certain impediments were removed, education and training of what it would entail to be licensed were provided or incentives were offered.

d. Trends

Concern about the relative fiscal health of the board and care system is not unique to Los Angeles County. In 2016, the CA Mental Health Planning Council initiated a statewide review of Residential Care Facilities in the state. They surveyed all 58 counties in CA, and 22 responded. (Los Angeles county was not one of the respondents.) The counties responded that 907 beds were needed, and 783 were lost over the past several years.[10] The respondents also indicated that in approximately 15 counties, beds had to be sought in another county because of the deficit in the home county.

According to the Planning Council, in their 2017 report, there were three main reasons why the shortage persists: (1) Financial; (2) Community Opposition, and (3) Staffing. Their data relative to the financial realities associated with running an adult residential facility will be described in greater detail below.

---

[9] It has been suggested that some licensed facilities are converting to unlicensed status. Such a facility may recruit residents from licensed facilities by promising them the ability to retain more of their monthly disability check. However, less services are provided. It is hard to obtain details about specific locations, as these facilities prefer to remain "off radar."

[10] Source: CMHPC October 2017 report; page. 5.

Another entity, the California Association of Local Behavioral Health Boards & Commissions, published an issue brief on ARF's in October, 2017 which outlined concerns about the "revolving door" when there are limited options for people coming out of acute in-patient treatment programs, transitional living or the correctional system.

In Los Angeles County, we assert that we are facing a crisis with respect to the survival of these precious housing resources. In just the past year, this ad-hoc commission received word that 11 board and care homes, ranging from 6 to 100+ beds, have closed, converted their operations or are considering closing. **This is just a small sample, pulled from our own network.** Examples of recent closures include:

- Brentwood Manor. This facility, located at 1449 Wellesley Avenue in Los Angeles was purchased in March, 2017 by a developer with the intention to transform it into a boutique hotel
- Western Ferndale Board and Care located at 1745 N. Western Avenue in Los Angeles
- Villa Poinsettia, 823 N. Poinsettia Pl, Los Angeles

These are facilities who have expressed concerns about their ability to continue their operations under the current scenario:

- Sunland Manor (approximately 100 beds), 10540 Sherman Grove Avenue, Sunland CA.
- Sepulveda Residential (approximately 80 beds). 8025 Sepulveda Blvd, Van Nuys, CA.
- Sharp Board & Care (6 beds), 10537 Sharp Avenue, Arleta, CA.
- Amigo Board & Care (two homes at 6 beds each), 8238 Amigo Avenue, Reseda and 23601 Vanowen, West Hills, CA.
- Blake Family Home (6 beds), 606 Jackman Street, Sylmar, CA.
- Alma Lodge (80 beds), 1750 Colorado Blvd, Eagle Rock, CA.
- Hartsook Board & Care (16 beds), 11045 Hartsook, North Hollywood, CA
- Golden State Lodge (14 beds), 11465 Gladstone Way, Lakeview Terrace, CA

Many of these have been in these neighborhoods for years. Owners who have run these businesses as family operations are now finding that the land is worth more that the business itself and are choosing to sell to developers. Not only are beds lost but opposition to opening other facilities in some of these communities proves insurmountable due to both the NIMBY mentality, changes in zoning and increased land and construction costs. Current board and care inventory ends up being used to re-house these displaced residents, further limiting options for homeless or new clients.

e. Financial Realities

With a reimbursement or rental rate of $35/day [11], a board and care operator is hard pressed to meet their obligations to provide the full array of services required under their licensing arrangement, with no relief in sight.

Further, the $134 that remains for the resident (from their social security disability check) must cover all their discretionary expenses including: clothing, transportation and travel, entertainment, cigarettes, and miscellaneous life expenses. This amounts to about $4 a day – a challenging amount for anyone to

[11] As of January 1, 2018, the rates have changed ever so slightly. SSI rates for clients are $1037 plus $20 if they receive disability. Personal spending for incidentals is $134.

consider. This explains why residents of board and care homes, who don't have access to supplemental funding from family or friends, may resort to panhandling to make ends meet.

DMH has initiated two strategies for addressing the financial viability and program needs of Board & Care facilities.

1) Under Whole Person Care DMH is currently amending contracts with existing Community Care Residential Facilities for a $25 per day patch for clients that have been determined to have higher needs.

2) In addition, DMH will be releasing a Request for Applications (RFA) Specialized Supplemental Care Program (SSCP) in the spring 2018 to offer funding for augmented supports to all licensed adult residential facilities across the county. The RFA will allow DMH to augment the Basic Rate to fund additional staffing needed to serve individuals that have a serious mental illness and, due to their level of functioning, symptoms, and psychiatric history, require service interventions that are in addition to or often more time-intensive to deliver than Basic Services. The payment of a supplemental rate will enable more placement options to individuals waiting to be transitioned from a higher level of care to the most appropriate residential setting based on their ability to function independently. The supplemental rate programs correspond to the level of service and/or staff. Funding will be offered for two different tiers of service: $25/day and $40/day.

Neither of these strategies has been fully implemented. And, as presented below, it is not clear that it will be enough. That is why it is essential that other community partners join in this effort.

The CA Mental Health Planning Council, in their October 2017 report presented a sample budget for a 13-resident facility. It documents in stark terms that the "rent" paid by residents does not even come close to covering the basic aspects of staffing, services and the facility costs. A break-even rent for this facility would require $2,805 per month. This budget is included as Table 1.

Table 1

Residential Care Facility Sample Annual Budget (13 Person)

Title	Amount	Comment
REVENUE		
Resident Fees	$160,056	$1026/month for 13 residents at 95% occupancy
Total Revenue	**$160,056**	
EXPENSES		
a. Personnel Expenses		
Line Staff	$182,000	4.5 Staff at $15/hour covers single coverage 7 days/week. Plus 1 FTE at 40 hours/week for administration/transport of clients to doctors, admissions, grocery shopping, etc at $20/hr.
Landscaping	$2400	$200/month
Relief Staff	$15,600	Fill-in for sick/vacation employees at 20 hours/week
Subtotal	$200,000	Presumes 9 sick days, 14 vacation days, 8 holidays/employee/year
b. Salary Related Expenses		
Health/Dental/Life/Vision Insurance (HSA)	$39,600	$600 month/employee, prorated for part-time for 5.5 employees. Rate is for minimal insurance.
Unemployment Insurance	$1,482	
Worker's Compensation Insurance	$13,836	

FICA/Medicare	$15,116	
Subtotal	$70,034	
c. Other		
Training	$2000	
Total Other Expenses	$2000	
Total Personnel Expenses	**$272,034**	
d. Operating Expenses		
Legal and Other Consultation	$1000	
Household Supplies	$10,000	Cleaning, paper supplies, non-food, any recreational supplies, linens, towels, paper goods
Office Supplies	$2,250	
Computer/Office Furnishings	$1000	
Utilities	$20,238	
Maintenance – Building and Equipment	$12,000	Presumes that this includes furniture and appliance replacement
Vehicle Maintenance	$6,000	Presume one vehicle for use at $550/month
Food	$40,880	$8 person/day plus one staff eating
Insurance	$8,215	
Telephone/Internet/Cable	$3000	
Printing and Postage	500	
Licensing and Permits	$1,711	
Property Taxes	$6,000	Presumes property purchased for $600,000 with $100,000 down payment
Advertising	500	
Total Operating Expenses	$113,294	
Rent or Loan Payments	$30,396	$500,000 loan for 30 years at 4.5%
Total Expenses	$415,724	
Total Net Income (Loss)	**(255,668)**	(Revenue $160,056 minus Cost $415,724 = Loss $255,668)

Source: CA Mental Health Planning Council, October 2017 report, page 9.

f. Case Studies

1. Golden State Lodge

In an example close to home, The Golden State Lodge, which has announced its intention to close, created a simple spreadsheet to document the fiscal strain that makes it impossible to operate without some additional source of funds. In this scenario, the assumptions are predicated upon a census that ranges between 10 to 13 guests per month. ***A break-even scenario would require a monthly rent of $2,500 per person.*** The full budget is included as Appendix C, but this abridged analysis documents the dilemma.

Table 2
Golden State Lodge 2017 budget

Category	Amount	Total
Revenue		
Resident rent	$ 122,100	
Total revenue		$ 122,100
Expenses		
Administration		
Payroll	$ 123,954	
Payroll taxes	$ 1,399	
Workers comp	$ 11,515	
Liability insurance	$ 9,757	
Property insurance	$ 9,900	
Employee insurance	$ 15,400	
Property taxes	$ 17,600	
Amortization	$ 41,800	
Continuing education	$ 2,200	
Total admin		$ 233,525
Operations		
Food	$ 19,500	
Utilities	$ 19,393	
Repairs/mtce.	$ 10,700	
Laundry	$ 2,750	
Housekeeping	$ 3,300	
Misc	$ 7,700	
Total operations		$ 63,343
Total		$ 296,868
Profit/Loss		$ (174,768)

2. Villa Stanley

At the April 27, 2017 hearing of the County Mental Health Commission on the topic of the board and care system, Dr. Jay Plotzker, Administrator for two facilities, presented specific information about the costs of running the two facilities, the demographics of the residents and the needs. (See Appendix B.)

His company runs two ARF's. Villa Stanley, licensed as an ARF in 1989, has 80 beds and is for non-ambulatory mentally ill clients. Villa Stanley East, licensed in 1999, has 62 beds. Residents are referred to Villa Stanley through social work personnel at area hospitals, families, social service agencies or DMH district offices.

Table 3
Villa Stanley Census

Tenure of Residents	Five years or more[12]	50%
	One to five years	30%
	Less than one year	20%
Gender	Male	80%
	Female	20%
Ethnicity	Caucasian	60%
	Hispanic	10%
	African American	22%
	Asian	8%
Age	18 – 35 years	20%
	35 – 60 years	60%
	60 and above	20%
Benefits	MediCal and SSI only	60%
	Medi-Medi SSI and SSA	25%
	VA	15%
Ongoing Therapy	Medi-Medi w/ PHP access	7%
	Veterans w/ MHICM or DDTP	5%
	FSP or Inter. Funding/DMH	15%
	No ongoing therapy	70%

In his testimony to the Commission, Dr. Plotzger outlined the demands placed upon the facilities. His prime concern is financial. In his words: "The board and care is paid for all its services a total (SSI basic rate) of $1;026.37 per month. That works out to $33.74 per day. That is an absurd amount given all that we provide to care, support and assist clients."

Dr. Plotzger provided the Commission with some insight into the service demands placed upon the board and care operator. With respect to client care, they have to tend to their financial issues in resolving SSA, VA or family-related payments.

They must also tend to their client's mental health needs – emergency and routine – even for those who have no ongoing relationship with a service provider. Because no more than 30 percent of the residents are receiving therapy at any given time, there is a tremendous need for the remainder to have access to case managers, doctors, clinical therapists.

There is a lack of access to educational, vocational or life-skills education. Particularly for younger residents, who might have an opportunity to wean themselves off government support, there is no support for vocational training. They must tend to the routine and emergency maintenance needs of

[12] According to Dr. Plotzker, some have lived at Villa Stanley for up to 20 years.

their facilities and be responsive to licensing requirements. They also have to stay connected with the community, to address the issues that typically come up in the neighborhood.

The reimbursement does not keep up with inflation. For example, he reports, the cumulative Consumer Price Index (CPI) for the LA area, since 2010, was 11.4%. Since 2010, the cumulative SSI/SSP increase has been only 6.4%. He suggested that with even a $5 or $10 per resident, per day increase, "there is much that we can do."

The future financial picture looks bleak. He expressed concern about the mandated increased in the minimum wage, and how that will impact their ability to comply with mandatory staffing of an ARF, as per Community Care Licensing guidelines. He anticipates increases in the cost of food, and related staffing costs related to preparation. He foresees increasing insurance costs (liability and medical) as well as Worker's Compensation. And finally, there is the ongoing costs associated with building repairs and maintenance. His facilities (as is the case with many others in the county) are aging and there are limited funds to handle capital improvements. He cited an example whereby two years ago, he had to pay $50,000 to replace an elevator.

In sum, if this system were funded more adequately, he suggested that the clients would have access to more therapy and services, activities, better food and nicer surroundings.

g. Quality of Facilities

This Ad-Hoc committee has limited its focus, for the most part to the financial issues facing board and care facilities and the critical need to stop the loss of these types of beds. There remains a real issue about the quality of life of those who live at facilities. Many of these facilities are run down and have multiple deferred maintenance needs. Owners will say that the money doesn't exist for them to do needed repairs, much less improve the cosmetic appearance of these facilities.

Financial pressures prevent most of these facilities from also providing any type of programming, therapeutic or otherwise. Many residents spend their days with little to do. Ironically, DMH and facilities have had to be careful in what they offer because of concerns of triggering the Federal IMD Exclusion. The exclusion prohibits Federal Financial Participation funds from being drawn down for mental health services if an owner of a facility is also the service provider on the site. That being said, DMH has developed some innovative programs such as the enriched residential facilities that enable providers to comply with regulations while offering treatment to clients, albeit at a nearby clinic site. We would argue that more can be done in this realm and hope that it will remain a topic of concern and focus.

III. CALL TO ACTION

First, it is important the county make a commitment to data collection to understand the trends relative to beds available for people with mental illness. The housing shortage is at a crisis level in L.A. County, and it is important to track this inventory to understand gaps and needs. The data collection, at the very least should:

- Identify the current inventory of ARF beds available for people living with serious mental illness today, and compare, to the extent possible, how the inventory has changed over the last one to five years;

- Identify the extent to which beds lost over the last one to five years have disappeared due to:
  - Conversion to another demographic group which offers greater subsidy
  - Conversion to unlicensed status
  - Sale of property for another use
  - Closure of home
- Identify if any new facilities have come on line in the last one to five years

Second, a sustainable commitment to enhanced funding needs to be identified to forestall additional shutdowns and to enhance quality of life for individuals living in these homes. It is estimated that "patches" or subsidies ranging from $64/day to $125/day (according to the CMHPC) would be necessary to maintain fiscal viability.[13] This will require more than just what is currently proposed for patches by DMH and other community partners must step in. The county should conduct an audit of ARF's of various sizes to ascertain what the extent of that patch would be in L.A. County to protect this housing inventory.

Third, it is recommended that policy makers who analyze housing supply and demand in Los Angeles County include Adult Residential Facilities in the continuum of community-based housing available for people with serious mental illness, as well as formerly homeless individuals. Arguably, formerly homeless residents with serious mental illness are more vulnerable than those targeted for permanent supportive housing with services attached. Surprisingly, under federal rules for defining "chronic homelessness," people leaving institutions are often not considered eligible for permanent supportive housing.

Fourth, in addition to shoring up the financial viability of board and care homes, it is critical to look beyond just the "brick and mortar" sustainability of these facilities and aspire to investing in opportunities for an enhance quality of life for those who live within this system. Patches above and beyond what is necessary to mitigate against closure will be required to invest in critical human needs including transportation of residents, linkage to day-time services and activities, and training for staff. Enrichment opportunities may also be generated by linkages to community services, adult schools, churches and volunteers, and this will require staffing and coordination.

Fifth, the Department of Mental Health should commit to a formalized liaison relationship with the board and care operators in order to provide support, training and an opportunity to dialogue about needs and aspirations.

Sixth, the county should identify a liaison with the California Mental Health Planning Council who has embraced this issue as a critical priority. The CMHPC has identified some state-level solutions that may require county policy support. Included in those recommendations is consideration for a "tiered level of care system" which would allow for different levels of reimbursement based upon resident needs (similar to what is done for residents with developmental disabilities.) The Planning Council has also recommended advocating for a higher State Supplemental Payment (SSP) rate.

[13] This recommendation is echoed by the CA Assoc. of Local Behavioral Health Board & Commission's report that indicates a patch of $64 to $125/day is needed to sustain operations for facilities >45 beds.